

**COMMONWEALTH OF VIRGINIA  
SCHOOL ENTRANCE HEALTH FORM**

*Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization*

**Part I - HEALTH INFORMATION FORM**

Part I to be completed by parents or guardians of students Ref Code of Virginia § 22.1-270, 1.

Student's Name: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_ Sex: ☐ Male ☐ Female Number of Children in Family: \_\_\_\_\_ State or County of Birth: \_\_\_\_\_

Student's Social Security # \_\_\_\_\_ or ID#: \_\_\_\_\_

Student's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of School \_\_\_\_\_ Grade \_\_\_\_\_

Name of Mother or legal Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Father or Legal Guardian: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In case of emergency --if parent or guardian cannot be contacted--contact the following:

1. Name: \_\_\_\_\_ Complete Phone Number: \_\_\_\_\_

2. Name: \_\_\_\_\_ Complete Phone Number: \_\_\_\_\_

Birth History (weight, premature and any other problems at birth): \_\_\_\_\_

ALLERGIES: (food, medicine, insect bites, and any other allergies): \_\_\_\_\_

Equipment Used and Specialized Health Care Needed (check all that apply and explain below.)*		Chronic Recurring, and Special Health Conditions (check all that apply and explain below.)*
<b>Equipment Used by Child:</b>	<b>Catheterization:</b>	Arthritis (rheumatoid)
Glasses/Contact Lens	Clean Intermittent Catheterization	Asthma
Hearing Aid	External Catheter	Attention-Deficit/Hyperactivity Disorder
Helmet	Other:	Behavioral or Developmental Problems
Wheelchair/Walker	<b>Medical Support Systems:</b>	Cerebral Palsy
Other:	Hickman/Broviac/VAC/MED	Cystic Fibrosis
	Mechanical Ventilator	Dental Problems
	Oxygen	Diabetes
<b>Specialized health Care Needed:</b>	Ventricular Peritoneal Shunt	Encopresis (involuntary discharge of stool)
<b>Activities of Daily Living:</b>	Other:	Enuresis (involuntary discharge of urine)
Bowel/Bladder Training	<b>Ostomies:</b>	Head or Spinal Injury
Diapering/Toileting	Ostomy Care	Hearing Impairment
Lifting/Positioning	Other::	Heart Disease
Other:	<b>Respiratory Assistance:</b>	Kidney Disease
<b>Feeding:</b>	Percussion	Muscular Dystrophy
Gastrostomy Feeding	Postural Drainage	Seizures
Jejunostomy Tube Feeding	Suctioning	Sickle Cell Disease (not trait)
Naso-Gastric Feeding	Other	Spina Bifida
Oral Feeding	<b>Specimen Collecting/Testing:</b>	Visual Impairment
Total Parenteral Feeding	Blood Glucose	Other:
Other:	Other :	

\*Explanation:

Describe any family history of chronic illnesses or genetic concerns (please list family member in relation to child [e.g., mother] and name of condition [e.g., anemia, arthritis, cancer, diabetes, heart disease, high blood pressure, kidney disease, mental illness, stroke, tuberculosis]): \_\_\_\_\_

List names of medical specialists or special clinics caring for your child: \_\_\_\_\_

Has your child ever been seen by a dentist? Yes ☐, No ☐. If yes, date of last appointment: \_\_\_\_\_ Name of dentist: \_\_\_\_\_

List all prescription and over-the-counter medications taken regularly by your child: \_\_\_\_\_

Describe your child's operations, and hospitalizations, if any (reason and date) \_\_\_\_\_

Describe any other important health-related information about your child: \_\_\_\_\_

Check here if you want to discuss confidential information with school nurse or other school authority. Yes ☐, No ☐.

Check here if you give permission for the school nurse or other school authority to contact the examining physician to discuss any information contained on this form. Yes ☐, No ☐.

Signature of Parent or Legal Guardian: \_\_\_\_\_ Date: (Mo., Day, Yr.): \_\_\_\_\_

**Part II - COMPREHENSIVE PHYSICAL EXAMINATION REPORT**

Part II to be completed by qualified licensed physician. All components, unless otherwise indicated, are to be performed no earlier than twelve months prior to the date child enters kindergarten or elementary school. Ref. Code of Virginia § 22.1-270, A-H

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Head Circumference: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_  
Mo. Day Yr.

Hemoglobin: \_\_\_\_\_ gms or Hematocrit: \_\_\_\_\_ % Urine: Albumin \_\_\_\_\_ Sugar: \_\_\_\_\_ Other: \_\_\_\_\_

Results of Mantoux tuberculin skin test, optional (may be required in high-risk groups): \_\_\_\_\_ mm. Date of test: \_\_\_\_\_  
Mo. Day Yr.

If performed, date of most recent blood lead level: \_\_\_\_\_ Results: \_\_\_\_\_ µg/dL  
Mo. Day Yr.

**Visual Screening:**

Distance visual acuity screening results, without correction: Right Eye 20/ \_\_\_\_\_ Left Eye 20/ \_\_\_\_\_ Both Eyes 0/ \_\_\_\_\_

Distance visual acuity screening results, with correction: Right Eye 20/ \_\_\_\_\_ Left Eye 20/ \_\_\_\_\_ Both Eyes 0/ \_\_\_\_\_

If performed stereopsis screening results: Pass: \_\_\_\_\_ Fail: \_\_\_\_\_

Child to be rescreened? Yes ☐ No ☐ Child to be referred? Yes ☐ No ☐

**Hearing:**

Hearing screening results: Right Ear \_\_\_\_\_ Left Ear \_\_\_\_\_ Equipment used: \_\_\_\_\_

If performed, hearing evaluation results: Right Ear \_\_\_\_\_ Left Ear \_\_\_\_\_

If indicated, Tympanogram: Normal: \_\_\_\_\_ Abnormal: \_\_\_\_\_

Child to be rescreened? Yes ☐ No ☐ Child to be referred? Yes ☐ No ☐

Systems Examination		Examined	Not Examined	Comments About Finding
General Appearance				
Nutritional Status				
Posture/Motor Behavior				
Skin				
Head				
Eyes:	External			
	Fundi			
Ears:	External and Canal			
	Tympanic Membrane			
Nose				
Throat				
Mouth/Teeth				
Neck				
Heart				
Lungs				
Abdomen				
Genitalia (Tanner Stage)				
Bones, Joints, Muscles				
Neurological				
Estimated Developmental Level:	Cognitive Development			
	Speed/Language Development			
	Social/Emotional Development			
	Health Behaviors/Health Habits			
Other:				

Summary of abnormal physical finding, if any: \_\_\_\_\_  
\_\_\_\_\_

Medical diagnoses: \_\_\_\_\_

Describe specifically what, if any, conditions are found that would identify the child as having a disability, including conditions that might require (1) educational evaluation, (2) environmental adjustment, or (3) activity limitation: \_\_\_\_\_  
\_\_\_\_\_

Assessment: \_\_\_\_\_

Recommendations and referrals made, if any: \_\_\_\_\_  
\_\_\_\_\_

Physician's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Physician's Name (print): \_\_\_\_\_ Phone No.: \_\_\_\_\_

Signature of Physician: \_\_\_\_\_ Date (Mo., Day, Yr.): \_\_\_\_\_

**Part III - CERTIFICATION OF IMMUNIZATION**

Part III to be completed by a physician or health department official

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle

Student's Social Security # : \_\_\_\_-\_\_\_\_-\_\_\_\_ or ID#: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1.	2.	3.	4.	5.
Diphtheria, Tetanus (DT) or Td given after 7 years of age)	1.	2.	3.	4.	5.
Poliomyelitis (OPV or IPV)	1.	2.	3.	4.	5.
Haemophilus Influenzae Type b (Hib Conjugate Vaccine)	1.	2.	3.	4.	
Measles (Rubeola)	1.	2.	Serological Confirmation of Measles Immunity:		
Rubella	1.	2.	Serological Confirmation of Rubella Immunity		
Mumps	1.	2.	Other (List type and date received)		
Measles, Mumps, Rubella (MMR vaccine)	1.	2.			
Hepatitis B Vaccine (HBV)	1.	2.	3.	Other:	
Varicella Vaccine	1.	2.	Other:	Other:	
Rotavirus Vaccine	1.	2.	3.	Other:	

**MEDICAL EXEMPTION:** As specified in the code of Virginia § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to the student's health. The vaccine(s) is (are) specifically contraindicated because (please specify): \_\_\_\_\_

DOTP/DTaP: [\_\_\_\_]; DT/Td: [\_\_\_\_]; OPV/IPV:[\_\_\_\_]; Hib: [\_\_\_\_]; HBV: [\_\_\_\_]; Measles: [\_\_\_\_]; Rubella: [\_\_\_\_]; Varicella: [\_\_\_\_]

This contraindication is permanent: [\_\_\_\_] or temporary [\_\_\_\_] and expected to preclude immunizations until: Date (Mo., Day, Yr.): \_\_\_\_/\_\_\_\_/\_\_\_\_

**RELIGIOUS EXEMPTION:** The code of Virginia allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services Ref. Code of Virginia § 22.1-271.2, C (I).

I certify that this student has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that the student has a plan for the completion of his/her requirements within the next 90 days (conditional enrollment).

Signature of Physician or health Department Official: \_\_\_\_\_ Date (Mo., Day, Yr.): \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that this student is ADEQUATELY IMMUNIZED in accordance with the MINIMUM requirements for attending school prescribed by the State Board of Health's Regulations for the Immunization of School Children (For information or questions or immunization regulations, please call your local health department or the Virginia Department of Health Division of Immunization, at 1-800-568-1929

Signature of Physician or health Department Official: \_\_\_\_\_ Date (Mo., Day, Yr.): \_\_\_\_/\_\_\_\_/\_\_\_\_